

## Waiting List Report Form

Agency Name: \_\_\_\_\_

Location: \_\_\_\_\_

Contact Person: _____ Contact Phone #: _____ (_____) _____ - _____	Reporting Month and Year: _____
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Service Setting	Residential No. of Beds	Residential No. of Beds Filled	Non-Residential Client Capacity	Non-Residential End of the Month Census

Priority Population Code	TDS Client ID	Initial Contact Date	Date and Agency Referred for Prenatal Care	Date and Agency Referred for HIV Testing	Date and Agency Entered Substance Abuse Treatment	Date of Agency Follow-up, Comments Disposition*

Priority Population Codes:

- 1 - Pregnant Injection Drug User
- 2 - Pregnant Substance Abuser
- 3 - Injection Drug User (within last 5 years)
- 4 - Male/Female Substance Abuser
- 5 - All Others (affected family members, ACOSs, etc.)

*\*Please place the date and a check mark in this box if the client doesn't call in to remain on the waiting list.*

*Please return the completed form to the Office of Substance Abuse no later than the 15th of the following month to Mary Beaudoin*

*Fax: (207) 287-4334 or email to [Mary.Beaudoin@maine.gov](mailto:Mary.Beaudoin@maine.gov)*

For OSA Use Only

Tx \_\_\_\_\_ Log \_\_\_\_\_ DE \_\_\_\_\_